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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Sri Lanka

The Executive Director recommends that the Executive Board approve the country programme of Sri Lanka for the period 1992-1996 in the amount of \$6,875,000 from general resources, subject to the availability of funds, and \$19,591,000 in supplementary funds, subject to the availability of specific-purpose contributions.

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* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1991, will be contained in the "Summary of 1992 recommendations for general resources and supplementary funding programmes" (E/ICEF/1992/P/L.2 and Add.1).

THE SITUATION OF CHILDREN AND WOMEN

1. After a very low gross domestic product (GDP) growth rate of 1.5 per cent in 1987, the economy in Sri Lanka is in the process of recovering, with a growth rate of 2.7 per cent in 1988 and 6.2 per cent in 1990. However, the prolonged civil strife in the north, north-east and south has continued to impact adversely on the economic and social conditions of the country, and substantial resources from the national income, about 6 per cent of GDP in 1990, were diverted to civil order and defence. Inflation has been accelerating, rising from a rate of 14 per cent in 1988 to above 20 per cent in 1990. Unemployment is estimated at 12 per cent, and some two thirds of the unemployed are youths. Foreign aid has continued to play a crucial role in economic restructuring and reconstruction programmes.

2. In 1990, the country's total population was estimated at 17.2 million, 1.8 million of whom were children under five years of age. The annual population growth rate has declined from 1.8 per cent in 1980 to 1.5 per cent in 1990 owing to a continued decrease in the birth rate. Urban population is about one fifth of the total population, and its growth rate has been generally lower than the national average. About 25 per cent of the total population live below the poverty line. The poorest groups include the urban poor, small-scale farmers, dry-zone farmers, settlers who live on rain-fed cultivation, estate workers, landless labourers, low-income fishing families, unemployed youths and the population living in areas of armed conflicts. The Government has launched its main poverty alleviation programme, the Janasaviya programme, to identify and help the poorest groups.

3. The infant mortality rate (IMR) continued to decline from 32 per 1,000 live births in 1986 to 26 per 1,000 in 1990. The well-established primary health care (PHC) infrastructure and the interventions made in the past decade for child survival and development activities, including universal child immunization (UCI), oral rehydration therapy (ORT) and improved care at delivery, have contributed favourably to the sustained decline of IMR despite the constraints posed by armed conflicts. Disparity, however, exists among different population groups, and IMR among the poorest groups may be double the national average. Surveys done by the Sri Lanka Department of Census and Statistics showed that infants in families with low levels of education, particularly families with no education at all, are far more vulnerable to early mortality than others. Leading causes of infant and child deaths are foetal malnutrition and immaturity, acute respiratory infections (ARI) and diarrhoeal diseases.

4. Sri Lanka is one of the few countries where a substantial reduction in national IMR has not been accompanied by a strong improvement in average nutritional status. If, however, the analysis is disaggregated geographically, there is a high correlation between IMR reduction and improved nutrition. Approximately 65 per cent of pregnant women suffer from anaemia, and babies with low birth weight, i.e., below 2,500 grams, account for 20 per cent of all newborns. Protein-energy malnutrition affects young

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children most severely between six months and two to three years of age. The most recent nutrition survey (1988/89) indicated that 18.4 per cent of children six months to five years of age suffer from wasting (-2 standard deviation) and 36.4 per cent suffer from stunting (-2 standard deviation). The deterioration of nutritional status at about six months of age is most likely caused by inadequate feeding practices. Low feeding frequency, combined with the relatively low energy density of the diet, results in inadequate dietary intake. At the age of six months, infections such as diarrhoea and ARI start to affect the child, and this, in turn, contributes to protein-energy malnutrition. The fact that nutritional status improves at the age of two to three years suggests that lack of food may not be an important cause of malnutrition. National nutrition surveys also show that child malnutrition is highest in the areas of highest household food consumption. The unequal consumption of food within the household reflects inadequate feeding practices.

5. The primary school enrolment ratio is above 95 per cent for both boys and girls, and the drop-out rate is less than 10 per cent. In 1990, the adult literacy rate was 93 per cent for males and 84 per cent for females. However, district-wise disparities continued to exist through the 1980s. The plantation districts, the backward eastern hinterland and the concentration of Muslim villages in the east have remained educationally disadvantaged. A 1989 survey of 398 small schools revealed that the average drop-out rate by grade 5 compared with that of grade 1 was about 20 per cent. Studies also show that among slums and shanties, some 20 per cent of school-age children have never attended school. As reflected in resource allocations, little priority is given to the learning needs of the young child. Preschools, day-care centres and crèches serve only about 20 per cent of preschool children.

6. Safe water supplies and sanitary latrines are available to 60 per cent of the population nationwide and 55 per cent of the population in rural areas. In some areas in the northern and eastern provinces, as well as in the north-western and north central provinces, coverage is much lower. Contamination of water by pesticides, insecticides, preservatives and adulterants is a growing problem. Large-scale deforestation, air pollution, industrial pollution, disposal of garbage in the cities and disposal of sewage are other problems of environmental concern.

7. Since the outbreak of the major armed conflict in mid-1990 in the north and east, some 1 million people have been displaced, 150,000 becoming refugees in India and the rest living in refugee camps in various districts of the country. Providing basic services to this large number of displaced people has become a major problem. Hospitals were damaged, many suffering from shortages of staff, equipment and drugs. As a result of the destruction of school buildings, the exodus of teachers, the displacement of children and the shortage of school supplies, education was interrupted as well. Many women have been psychologically traumatized and have lost their husbands. The psycho-social effects of the conflicts on children are severe and many are unable to function normally. In addition, many physical disabilities have resulted from the war, and many children have lost their parents.

8. Child labour and street children have received increased public attention as part of follow-up on the Convention on the Rights of the Child. The country has not yet enforced any regulatory legal controls to protect children from exploitation. It is estimated that there are 500,000 working children, many of them domestic servants. Child prostitution is believed to be widespread in the tourist zones, with an estimated 30,000 boy prostitutes. There may be as many as 10,000 street children in the country.

PROGRAMME COOPERATION, 1989-1991

9. The country programme for 1989-1993 was reduced to three years, 1989-1991, because the annual programme budget levels were increased for relief and rehabilitation activities. Accordingly, funds approved for the 1989-1993 period of cooperation were disbursed ahead of schedule.

Health

10. Despite the serious social crisis caused by armed conflicts, UCI was achieved in 1989 and has been sustained over the past three years. National immunization coverage for children under one year of age has been maintained at above 80 per cent for all antigens. Communication and social mobilization have played a crucial role in keeping the commitment of political leadership, as well as the continued demand for immunization service among mothers. Since the UCI project is integrated with other maternal and child health (MCH) activities, efforts to reach the UCI target have thus strengthened the existing infrastructure for health service delivery. New medical officers have been recruited and their training has begun. The Government is assuming greater responsibilities in sustaining the project by providing funds for vaccine supplies. The project has been implemented in close collaboration with the World Health Organization (WHO), Rotary International and the Swedish International Development Authority.

11. The national control of diarrhoeal diseases (CDD) project continued its two-pronged approach of prevention of dehydration through home-based preparations, including the traditional rice, kanji, and the treatment of mild and moderate dehydration through the use of Jeevatee, the local brand of oral rehydration salts (ORS). About 1 million packets of Jeevatee were produced and distributed with government support. Communication campaigns were launched for the promotion of ORS and ORT, combined with promotion of breast-feeding and hygiene education. A 1990 survey carried out by the Ministry of Health showed that the ORS usage rate was 58 per cent, and mothers' knowledge about ORS and continued breast-feeding during episodes of diarrhoea was above 96 per cent, thus meeting coverage targets set at the beginning of the programme cycle. Comprehensive antenatal care was provided for 77 per cent of pregnant women, and the goal of institutional delivery for 80 per cent of pregnant women was achieved. The ARI project has been initiated; about 40 per cent of medical professionals have received training, and some educational materials have been prepared and printed.

Nutrition

12. The approach so far has been to focus on inadequate household food security as the major underlying cause of malnutrition. The support provided included promotion of breast-feeding, proper weight gain during pregnancy, growth monitoring of children under five years of age and growth promotion through food supplementation and home food production. Child health and development charts were developed and provided to mothers, covering an estimated 50 per cent of children for early identification of the onset of undernutrition. Through the area-based programmes, activities for home food production and training of agricultural extension staff and village leaders were carried out. Given the serious nutrition situation, there is a strong need for greater support to nutrition-oriented programmes in the future. More attention needs to be given to factors such as inadequate care of children and women and the incidence of infectious diseases as equally important underlying causes of malnutrition.

Education

13. Support has focused on three areas: improving the quality of education in small, disadvantaged primary schools; special education; and selected activities in non-formal education. The National Institute of Education has begun to define minimum levels of learning expected for each grade up to grade 5. Support was provided for 250 small, disadvantaged schools to reduce education disparities, and the teachers of these schools were trained in multigrade and multiclassroom management strategies, remedial measures for children faltering academically and approaches to build positive community-school relationships. Some initial efforts have been made to link teaching and learning activities with agriculture through the curriculum in environmental education and the sciences. Very encouraging results have been achieved in developing training materials for classroom activities in conflict resolution. Teacher trainers were also trained in conflict resolution concepts and strategies.

14. In non-formal education, assistance was extended to areas where drop-out rates were high and to communities where local non-governmental organizations (NGOs) were active in organizing literacy classes. The normal five-year curriculum was condensed into two years, and a major effort is under way to formally develop equivalency tests for the easy transfer of children into the formal system. About 400 literacy centres received assistance and 400 teachers received basic training and refresher training, benefiting 10,000 children from 5 to 14 years of age. Initiative has been taken to connect efforts in special education with community-based rehabilitation. Training was provided for volunteers in seven districts with a total population of 222,000. About 12,000 disabled children were identified for treatment. In early childhood development, support was given to NGOs and area-based programmes in the development of an infrastructure for early childhood care and in the provision of teaching/learning materials for use by those providing child care.

Area-based programmes

15. In collaboration with the Canadian International Development Agency, the Netherlands and Norway, area-based programmes in Puttalam District, the estates, and the Mahaweli resettlement programme were supported, along with an urban basic services project covering 14 cities. However, since many of the activities were located in areas directly affected by armed conflict, implementation has been delayed to varying degrees. Mahaweli and some of the urban basic services project cities were most seriously affected. In the Puttalam integrated basic services project, 10 dry-zone areas were selected for focal support, and a knowledge, attitude and practice study on water supply and sanitation was completed. Through community-level action, the urban basic services project extended basic services, including health, water supply and sanitation, pre-schools and playgrounds, to benefit above 100,000 people in about 150 slums and shanty areas. The project was closely linked with the government shelter upgrading programme for the urban poor.

16. In the estates project, an MCH structure has been established to strengthen maternal health care, immunization, nutrition and health education. Regional vaccine centres have also been established and 1,000 health staff, including midwives and family welfare personnel, were trained and retrained to improve MCH services. Packets of ORS, iron dextran injections, iron tablets and other essential drugs were provided through 500 health centres. All 1,600 crèches on the plantations have been upgraded and made functional for the provision of child care and other health and welfare services. About 600 piped water supply schemes and over 5,000 sanitary latrines were constructed in various poor estates.

Relief and rehabilitation

17. This programme, which began in early 1988, aimed at addressing the unmet needs of children and mothers in conflict areas. By the end of 1991, an aggregate amount of \$2,200,000 had been additionally allocated from general resources and contributed through supplementary funding for relief and rehabilitation activities by various donors, including Japan, the United Kingdom of Great Britain and Northern Ireland, the United States of America and Australia. In collaboration with government agencies, the International Committee of the Red Cross (ICRC) and local NGOs, medical and other emergency supplies were provided for the approximately 250,000 displaced persons residing in 287 camps since the outbreak of civil strife in mid-1990. Initiatives have been taken to reduce the psychological effects of armed conflicts on children through village volunteers under the PHC programmes. Community-based rehabilitation activities focusing on the needs of children were undertaken in clusters of villages in the six most affected districts in the north and east.

Advocacy and social mobilization

18. The Convention on the Rights of the Child, the World Summit for Children and the World Conference on Education for All provided opportunities for advocacy on behalf of the well-being of children with political leadership, judges and law enforcement officers. A parliamentarians' meeting was held in 1990, which mobilized support for child rights and discussed a mechanism to monitor implementation of the Convention. Sri Lanka ratified the Convention and the President signed the Declaration and Plan of Action of the Summit. A national programme of action for children was prepared, which adapted all the major 1990s goals set by the Summit to the context of the country. Sri Lanka has also been active in promoting the follow-up of the Summit in the region through the South Asian Association for Regional Cooperation (SAARC) summit meetings, and the second SAARC conference on South Asian children will be hosted by Sri Lanka in 1992. At the programme level, communications and social mobilization were built into all the major programmes, and Facts for Life was distributed and used extensively for advocacy and social mobilization purposes.

RECOMMENDED PROGRAMME COOPERATION, 1992-1996

Recommended general resources: \$ 6,875,000
Supplementary funding: \$19,591,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	<u>General resources</u>	<u>Supplementary funds b/</u>	<u>Total</u>
Health	2 245	1 628	3 873
Nutrition	1 411	3 750	5 161
Education	995	1 463	2 458
Water supply and sanitation	224	2 038	2 262
Children in especially difficult circumstances	495	3 398	3 893
Emergency relief and rehabilitation	620	3 064	3 684
Area-based programmes	-	4 250	4 250
Advocacy and planning	385	-	385
Programme support	<u>500</u>	<u>-</u>	<u>500</u>
Total	<u>6 875</u>	<u>19 591</u>	<u>26 466</u>

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Programme preparation process

19. The preparation of the country programme for the period 1992-1996 began immediately after the World Summit for Children was convened. The Summit Declaration, the Convention on the Rights of the Child and the Jomtien Declaration on Education for All have provided the guidelines for formulation of the new country programme. The situation analysis of children and women in Sri Lanka, prepared jointly with the Government in 1991, highlighted the challenges and opportunities for the eventual achievement of the 1990s goals. The strategy meeting and the preview of the proposed country programme were attended by high-level government officials and UNICEF staff, including the Deputy Executive Director for Operations and the Regional Director for South Asia. Other United Nations agencies, bilateral donors and local NGOs were also involved in the overall consultations, as well as in the process of developing individual programmes.

Major national goals

20. The 1992-1996 programme of cooperation aims to advance the following national goals and objectives reflected in the national programme of action for children prepared by the National Planning Department, Ministry of Policy Planning and Implementation: (a) to reduce IMR to 19 per 1,000 live births; (b) to reduce the maternal mortality rate (MMR) by 15 per cent and to ensure that no district will have an MMR above 50 per 100,000 live births; (c) to sustain UCI and to eradicate polio myelitis and neonatal tetanus and to achieve a 90 per cent reduction in the incidence of measles; (d) to reduce the level of malnutrition in children under five years of age from 35 to 25 per cent; (e) to achieve universal access to safe drinking water and sanitary latrines by the year 2000; (f) to achieve universal basic education; and (g) to improve the protection of children in difficult circumstances, in particular, working children, street children and children in situations of armed conflicts.

Health

21. The programme will continue to consolidate and sustain universal immunization coverage of infants and further increase coverage to 90 per cent in each of the 25 administrative districts. Special attention will be given to pocket areas where coverage is particularly low, including urban slums and conflict-torn areas, where outbreaks of polio myelitis have often occurred. In collaboration with WHO, Rotary International, the Swedish International Development Authority and other bilateral donors, vaccines will continue to be provided, and the Government will be encouraged to increase its funding for vaccine supplies. Cold-chain maintenance will be supported and training will be provided for the 288 newly recruited medical officers. Disease surveillance systems at all levels will be strengthened, and communication and social mobilization will be emphasized to maintain the political commitment and demand for services among mothers.

22. CDD will continue to be implemented through the promotion of ORS/ORT, breast-feeding and hygiene education. The programme aims to increase further the rate of proper use of ORT among families in need to 80 per cent. Communication activities will be stressed for social marketing of ORS, preparation and the use of ORT and ORS, personal hygiene and continued feeding during episodes of diarrhoea. Control of ARI in the 1.8 million children under five years of age will also be an area of focus. Standardized case management of ARI will be introduced in the entire health care system, and mass media and other channels of communications will be used to create awareness about this new approach among mothers. Safe motherhood will be promoted by improving the management of MCH services, with special emphasis on selected geographical areas.

Nutrition

23. The main thrust of the 1992-1996 programme of cooperation will be to address the problem of malnutrition. A national-level dialogue will be initiated to achieve a consensus on the nature of the nutrition problem. At the same time, a number of specific areas will be chosen for priority attention, according to the severity of the problem. As intervention activities and procedures are refined, they will be expanded to a national implementation strategy, to be primarily supported by the Government and through other external resources. Communities will be encouraged and assisted to assess and analyse their nutrition problems and to design appropriate actions, primarily using their own resources. Once the most important, immediate, underlying and basic causes have been identified, a set of interventions can be implemented. The outcome will be closely monitored by the community itself in order to improve gradually the understanding of the problem and to enable the community to design new and more appropriate interventions if necessary. Local health, education, agriculture, planning and administration officials will be involved in all aspects of programme planning, implementation and monitoring.

24. The same process will be initiated at the household level. By monitoring the growth of young children, specific household and individual actions will be promoted and household resources will be mobilized. Since growth monitoring and promotion do not require the construction of facilities, these activities will take place in existing buildings, such as health care centres, schools and religious centres, as appropriate. Training will be provided for family health workers, health volunteers and local teachers. The Assistant Government Agency divisions, each consisting of between 15,000 and 60,000 people, will be the largest administrative unit for programme focus. Five of these divisions will be selected each year, and a total coverage of 25 divisions will be reached by 1996. Those divisions that have been selected by the Government for the Janasaviya poverty alleviation programme will be the focus of interventions. Support will also be given to the ongoing efforts of national and local agencies and NGOs to increase family food production and education on appropriate food habits. The school curriculum, through environmental education and science lessons, will emphasize practical agricultural activities consonant with local conditions. Special advocacy

efforts will be developed to promote "baby-friendly" hospitals and maternal services.

Education

25. While continued efforts will be made to reduce area-wise disparities among schools, the programme will focus on nutrition education and improvement of the nutritional status of primary school children and pre-adolescent and adolescent girls through direct school-based interventions. The programme also aims to improve school environment, classroom learning activities, school attendance, early identification of educational faltering, early identification of disabilities, teacher training and formal and non-formal educational initiatives to prepare young girls and women to participate in the adult world. A total of 150 primary schools will be selected each year for integrated activities. About 25,000 copies each of a teacher's manual on nutrition and supplementary reading materials will be published and distributed to the 9,650 schools throughout the country, and 20 quarterly training sessions will be conducted at the provincial level to reach about 20,000 primary teachers. For preschool education, advocacy efforts will aim to establish a focal point in the Government, and support will be given to family-based, early childhood stimulation activities through community organizations and volunteers in order to complement growth promotion, preparation for formal education and impart life-long positive health practices.

Water supply and environmental sanitation

26. At the national level, the programme will focus on strengthening the national capacity in programme development, implementation and water quality monitoring. Support will be given to help establish a community-based maintenance system for hand pumps and to strengthen the existing water quality monitoring system. Training will be provided for 160 village hand-pump mechanics, 1,000 public health workers and 250 trainers in the use of smokeless stoves. At the local level, water supply and sanitation interventions will be linked with other health and nutrition activities to form an integrated package of basic services through the area-based programmes. Planned 1996 targets include the construction of a total of 1,600 wells and 52,000 household latrines, and the training of a total of 12,000 health volunteers and technicians.

Children in especially difficult circumstances

27. The programme will advocate for legislation to protect children in especially difficult circumstances. The focus will be on education in conflict resolution and on the psycho-social needs, rehabilitation and protection of children in armed conflict. Education in solving conflicts by peaceful means, experimentally initiated with success in the last programme cycle, will be expanded to all formal and non-formal education systems, supported by strong media and communication activities. Support will be given to develop conflict-resolution teaching and learning materials in Tamil,

Sinhala and English; to provide training to teachers; and to develop and air television and radio materials. Psycho-social support for children affected by the trauma of violence will be provided through the PHC infrastructure of the areas concerned, using both health workers and volunteer groups. Play therapy and other cultural activities will be promoted, and about 10,000 community-based rehabilitation volunteers will be trained to provide improved services for disabled children in conflict-affected areas.

Emergency relief and rehabilitation

28. The programme aims to provide access to basic health and nutrition services, shelter, clean drinking water and sanitation facilities for families rendered homeless and living in camps, and to provide continued education for their children. To achieve sustainability and long-term progress, a developmental approach to rehabilitation will be adopted. The community will be actively involved in all aspects of planning, implementation, monitoring and evaluation. Relief and supplies will be provided for approximately 1 million displaced persons in the north, east and border areas. Support will also be provided to train about 500 volunteers and to upgrade village health centres. Training and provision of materials for peace education will serve 25,000 children. Approximately 2,500 families, particularly households headed by women, will benefit from village-based, income-generating activities. About 300 wells and 5,000 toilets will be constructed to serve around 100,000 people.

Area-based programmes

29. This programme consists of three projects: services for children on estates; urban basic services; and Puttalam integrated basic services. In collaboration with the national medium-term investment programme, the estates project aims to improve the well-being of the long-isolated 500,000 minority women and children on the plantations. About 400 each of medical assistants, midwives and family welfare supervisors will receive refresher training in health and nutrition; 2,000 crèche workers will be trained in child care and health education; and 15,000 mothers' health cards will be distributed each year to identify mothers at risk. The urban basic services project aims at improving the basic services for 700,000 people living in the urban slums and squatter settlements of 14 selected cities. Community leaders will be trained to identify priority needs and actions in order to develop their poor urban neighbourhoods. Convergent interventions will be supported for both the urban basic services and the Puttalam integrated basic services projects. These include immunization, ORS, MCH services, food supplementation, early childhood development, safe drinking water and sanitary latrines, skills training and capacity-building. For the urban basic services project, advocacy for street children will be stressed.

Advocacy and social mobilization

30. The programme will focus on advocacy for children, programme communication and community education, public information, alliance-building

and institutional capacity-building in order to ensure follow-up on the World Summit for Children and the implementation of the Convention on the Rights of the Child and the national programme of action for children in Sri Lanka. Advocacy will be carried out to involve legislators, policy planners, religious dignitaries, media and government and NGOs in the promotion of the welfare of children and women, using Facts for Life as a basic reference for advocacy messages. All programme communication activities will be designed to converge on the ultimate goal of reduction of the incidence of child undernutrition. Public information will be strengthened through press conferences, media briefings, field visits to projects and production and distribution of information support materials for donors, media and the general public, to help build a child-focused grand alliance.

Management, monitoring and evaluation

31. The Department of External Resources of the Ministry of Finance is the government focal point for the overall coordination of the programme of cooperation. The Ministry will ensure the necessary integration and coordination required between the various components of the programmes and with the overall efforts of the Government and other external agencies devoted to the implementation of the national programme of action for children. Regular field visits, quarterly monitoring meetings, annual reviews and a 1994 mid-term review of the country programme will be held jointly by the Government and UNICEF to review the achievement of implementation objectives, financial input and programme/project work plans, and to suggest any corrective actions where required. Project managers, relevant NGOs and other United Nations agencies will attend these meetings. Detailed plans for monitoring and evaluation will also be developed for individual programmes of the country programme.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Sri Lanka		(1990 and earlier years)	UNICEF country classification	
Under-five mortality rate	35	(1990)	Middle USMR	
Infant mortality rate	26	(1990)	Middle IMR	
GNP per capita	\$ 470	(1990)	Low GNP	
Total population	17.2 Millions	(1990)		

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1990
Births	(thousands)	375	412	406	369
Infant deaths (under 1)	(thousands)	22	16	13	10
Under-five deaths	(thousands)	30	22	19	13
Under-five mortality rate		80	53	48	35
(per 1,000 live births)					
Infant mortality rate (under 1)		59	40	32	26
(per 1,000 live births)					
		About 1980	Most recent		
Underweight children (under 5)	Moderate & severe	..	38g		
(% weight for age, 1980/1987)	Severe	..	9g		
Babies with low birth weight		21	25*		
(%, 1979/1987)					
% of primary school children		91	94		
reaching final grade (1980/1988)					

NUTRITION INDICATORS		About 1980	Most recent	
Mothers breast-feeding at 3/6/12 months		83/ 74/ 48	94/ 80/ 72	
(%, 1980/1987)				
Prevalence of wasting (%, 1978/1987)		23b	19	
Prevalence of stunting (%, 1978/1987)		54b	34c	
Daily per capita calorie supply				
(% of requirements, 1979-1981/1988)		100	104	
Food production per capita index		102	89	
(Index 1979-1981=100, 1980/1990)				
Household expenditure	All food/cereals		43/ 18	
(% of total income, 1980-1985)				

HEALTH INDICATORS		About 1980	Most recent	
ORT use rate (%, 1989)			58	
Access to health services	Total	93	..	
(% of population, 1980)	Urban/rural	.. / ..	.. / ..	
Access to safe water	Total	19*	60	
(% of population, 1980/1990)	Urban/rural	49* / 10*	100/ 64	
Access to adequate sanitation	Total	67	45	
(% of population, 1980/1985)	Urban/rural	80 / 63	65/ 39	
Births attended by trained personnel		85	94	
(%, 1980/1983-1987)				
Maternal mortality rate				
(per 100,000 live births, 1987)		..	80	
Immunization		1981	1985	1990
One-year-olds (%) immunized against:	Tuberculosis	58	74	..
	DPT	45	71	..
	Polio	49	65	..
	Measles	..	20	..
Pregnant women (%) immunized against	Tetanus	48	36	..

TABLE 1 (continued)

Sri Lanka

EDUCATION INDICATORS		About 1980		Most recent		
Primary enrolment ratio (gross/net) (%, 1980/1987)	Total	103/ ..		107/ ..		
	Male	105/ ..		108/ ..		
	Female	100/ ..		105/ ..		
Secondary enrolment ratio (gross/net) (%, 1980/1987)	Total	55/ ..		71/ ..		
	Male	53/ ..		68/ ..		
	Female	57/ ..		74/ ..		
Adult literacy rate, 15 years & older (%, 1970/1990)	Total	77		88		
	Male/female	85/ 69		93/ 84		
Radio/television sets (per 1,000 population, 1980/1988)		81/ 2		191/ 32		
DEMOGRAPHIC INDICATORS		1970	1980	1985	1990	2000**
Total population	(Million)	12.5	14.8	16.1	17.2	19.4
Population aged 0-15 years	(Thousands)	..	5555.2	5832.3	5952.5	5687.3
Population aged 0-4 years	(Thousands)	..	1853.6	1996.3	1814.2	1736.2
Urban population (% of total)		22	22	21	21	24
Life expectancy at birth (years)	Total	65	68	70	71	73
	Male	64	66	68	69	71
	Female	66	70	72	73	75
Total fertility rate		4.3	3.5	3.0	2.6	2.2
Crude birth rate (per 1,000 population)		30	28	25	22	18
Crude death rate (per 1,000 population)		8	7	6	6	6
		About 1980		Most recent		
Contraceptive prevalence rate (%, 1977/1987)		41		62		
Population annual growth rate (%, 1965-1980/1980-1990)	Total	1.8		1.5		
	Urban	2.3		1.4		
ECONOMIC INDICATORS		About 1980		Most recent		
GNP per capita annual growth rate (%, 1965-1980/1980-1990)		2.8		2.4		
Inflation rate (%, 1965-1980/1980-1989)		10		11		
Population in absolute poverty (%)	Urban/rural	../..		../..		
Household income share (%, 1980-1981)	Top 20%/bottom 40%	50/ 16		../..		
Government expenditure (% of total expenditure, 1980/1988)	Health/education	5/ 7		6/ 11		
Household expenditure (% of total income, 1980-1985)	Defence	2		7		
	Health/education			3/ 3		
Official development assistance: (1980/1989)	US\$ millions	390		558		
Debt service	As % of GNP	10		8		
(% of goods & services exports, 1980/1989)		6		13		

a/ Aged 3-36 months. b/ Rural only. c/ Aged 24-36 months.

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

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TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1989-1991

(In thousands of United States dollars)

COUNTRY: SRI LANKA
LATEST BOARD APPROVAL: 1989
GENERAL RESOURCES: \$5,300,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	1336	1912	12	43	57	385	139	298	1544	2638	4182
Water supply and sanitation	195	772	4	36			13	615	212	1423	1635
Nutrition	527	50	13		79	26	59	23	678	99	777
Education	195	280	17	30	4		82	48	298	358	656
Community organization and development	16	50	26	51			110	67	152	168	320
Young child development	72	30	30	20	29		24	21	155	71	226
Women-centred programme		2						5		7	7
Children in especially difficult circumstances	75		5		1		15	2	96	2	98
Advocacy	2	13	20				41	17	63	30	93
Emergency	618	1304	3	18	34		182	2	837	1324	2161
Planning and project support	20	22	4	18	125	840	106	66	255	946	1201
Freight		9					8		8	9	17
GRAND TOTAL	3056	4444	134	216	329	1251	779	1164	4298	7075	11373

GR = General resources.
FSF = Funded supplementary funding.

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TABLE 3. PLANNED EXPENDITURE, 1992-1996

(In thousands of United States dollars)

Country: SRI LANKA Period covered: 1992-1996	Funding status	1992	1993	1994	1995	1996	Total
Health	GR	445	445	460	435	460	2245
	NSF	600	400	200	200	228	1628
Nutrition	GR	259	249	264	315	324	1411
	NSF	600	600	650	900	1000	3750
Education	GR	172	181	195	219	228	995
	FSF	300	470				770
	NSF			463	500	500	1463
Water supply and sanitation	GR	34	40	51	46	53	224
	NSF	335	385	401	315	602	2038
Children in especially difficult circumstances	GR	100	95	100	100	100	495
	NSF	610	745	686	691	666	3398
Emergency relief	GR	190	190	130	80	30	620
	NSF	458	456	735	710	705	3064
Integrated area-based programme	FSF	2489	738	470			3697
	NSF	395	410	1055	1400	990	4250
Advocacy and planning	GR	75	75	75	80	80	385
Programme support	GR	100	100	100	100	100	500
TOTAL	GR	1375	1375	1375	1375	1375	6875
	FSF	2789	1208	470			4467
	NSF	2998	2996	4190	4716	4691	19591
GRAND TOTAL		7162	5579	6035	6091	6066	30933

GR = General resources.

NSF = New supplementary funding.

FSF = Funded supplementary funding.

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TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: SRI LANKA	Number of posts	Amount (Thousands of United States dollars)

FINANCED FROM 1992-1993 APPROVED BUDGET:		
International Professional established posts	2	390
Local national Professional and General Service established posts	15	313
Operating costs		744

Total	17	1447

FINANCED FROM PROGRAMME FUNDS: <u>a/</u>		
International Professional project posts		
General resources		
Supplementary funds	4	724
Local national Professional and General Service project posts		
General resources	9	133
Supplementary funds	15	241

Total	28	1098

a/ For information source, see the 1992 revised post authorization table,
dated 23 July 1991.



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UNITED NATIONS CHILDREN'S FUND
Programme Committee
1992 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Lebanon

The Executive Director recommends that the Executive Board approve the country programme of Lebanon for the period 1992-1996 in the amount of \$5 million from general resources, subject to the availability of funds, and \$20 million in supplementary funds, subject to the availability of specific-purpose contributions.

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* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1991, will be contained in the "Summary of 1992 recommendations for general resources and supplementary funding programmes" (E/ICEF/1992/P/L.2 and Add.1).

THE SITUATION OF CHILDREN AND WOMEN

1. The year 1991 marked the return of peace to Lebanon after 16 years of brutal civil war. The climate of despair has for the most part been replaced by one of hope for a peaceful future as the process of national reconciliation and reconstruction takes root. The Taef Agreement has set the stage for constitutional changes and has empowered the Government to reassert central authority in much of the country. Nevertheless, with parts of the country still in conflict and the repercussions of regional peace negotiations still uncertain, a complete return to normalcy remains a long way off.

2. Lebanon's population has been estimated at 2.7 million, with a growth rate of 2 per cent per year. The civil war has resulted in dramatic rural-to-urban migration as large numbers of people have moved from conflict zones to areas of safety. Based on United Nations Population Division statistics, the rural population is now only 13 per cent of the total, down from 40 per cent in 1970. This urbanization has taken a heavy toll as the basic infrastructure, water and sanitation networks and housing have failed to keep pace with the rapid urban growth. It has also been estimated that 1.4 million Lebanese have been displaced during the war, of whom 800,000 permanently. An additional destructive byproduct of the war has been the massive emigration of skilled personnel. During the first 12 years, 650,000 people were estimated to have fled the country. In 1989-1990, a further 350,000 are believed to have left, and in recent years there has been a noticeable trend of young and well-educated professionals leaving.

3. The prolonged war has led to the decimation of the economy and the destruction of the economic infrastructure. A 1988 United Nations Development Programme (UNDP) study estimated per capita gross national product (GNP) at \$1,260, down from \$2,250 in 1975. The United Nations Statistical Office, however, estimates GNP per capita at \$2,150 in 1989. At the household level, it is estimated that the average Lebanese salary has declined by over 76 per cent in real terms since 1976. At the same time, increases in the cost of food, medicines and education have been significant, leading to a growing number of families unable to afford the basic necessities of life.

4. Over the last 15 years, the Government has been unable to intervene on a national scale in the social sectors, leaving a void in terms of both health policy and on-the-ground service. The private sector now accounts for two thirds of primary health care (PHC) services and 92 per cent of hospital services. Health care at the district level in Lebanon is provided mainly by a disparate network of clinics and dispensaries run by more than 250 non-governmental organizations (NGOs), most operating independently. Similarly, the 109 governmental dispensaries operate with little coordination. It is estimated that 40 per cent of the population, primarily those without any form of insurance, receive care through this network. Eighty per cent of the Ministry of Health budget goes towards reimbursing private-sector hospital costs. These factors have resulted in high user costs, overdependence on the private sector, breakdown in the social security

safety net system and significant geographical disparities in access to and quality of services. Recent studies on basic services have found that it is precisely those areas least affected directly by the war that have the lowest access rates since emergency assistance was concentrated in the main conflict zones.

5. A 1990 Ministry of Health/UNICEF/World Health Organization (WHO) survey estimated the infant mortality rate (IMR) at 35 per 1,000 live births and the under-five mortality rate (USMR) at 43 per 1,000 live births. While nationwide figures for infant and child mortality are relatively low in relation to other countries in the region, results indicate geographical disparities, with the north and Bekaa regions having significantly worse indicators. Recent information on the major causes of infant and child mortality is extremely limited, but selective studies suggest that acute respiratory infections (ARIs) (pneumonia), gastroenteritis, hepatitis, meningitis and vaccine-preventable diseases such as measles are the leading causes of death. Some of the identified underlying causes are low birth weight, inadequate access to health services, inadequate safe motherhood practices and education and age of the mother.

6. A 1991 UNICEF breast-feeding survey estimated the incidence of low birth weight at 9.5 per cent nationally, with 4 per cent in East Beirut and 10 per cent in West Beirut and the north. Micronutrient deficiency disorders are reported to be low, except for goitre, which is found primarily in the mountainous regions. The survey indicated that over 90 per cent of mothers were breast-feeding their latest child, but also revealed that only 13 per cent of mothers breast-feed exclusively for the first three months. Geographical disparities exist, with high breast-feeding rates in rural areas and significantly lower rates in urban areas.

7. The formal education system has been paralysed by the civil war. Gross enrolment in primary education is estimated to be between 70 and 80 per cent, with no indication of gender disparity. Recent Ministry of Education reports indicate that 35 schools have been totally destroyed, 49 partially destroyed, 46 occupied by displaced people and 290 are in need of some repair. Studies suggest that 50 per cent of teachers possess only an upper elementary level of education, and that only 26 per cent of teachers have received proper training. In response to urgent needs, the Government has had to contract 5,000 untrained teachers. Studies also indicate 20 to 30 per cent repeater rates and a 50 per cent drop-out rate. Low levels of teacher performance, outmoded teaching methods, irrelevant curricula and barriers to access posed by cost and geographical disparities further undermine the education system. Underlying those factors is the lack of a well-defined national policy on education and the growing gap between private and public school systems.

8. The general situation of women in Lebanon is among the best in the region. Nevertheless, early marriage and the excessive workload among rural women limit their participation in development. Family planning appears to be well accepted, but services are restricted mainly to the private sector, which limits access by the poor and rural communities. Urban hospital records indicate that maternal mortality rates are low, but geographical disparities

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are expected owing to the limited availability of perinatal services in the Bekaa and the north. Generally, there are insufficient data on Lebanese women to have a clear and authoritative picture of their position in society. Obtaining this information is an urgent requirement for future programming.

9. Less visible than the damage to property, but no less tragic, has been the war's impact on Lebanon's children: psychological impairment; post-traumatic stress; loss of education and health services; abandonment; death of parents; and disability. For an entire generation of Lebanese children, war has been the only reality they have ever known. This generation of children's attitudes towards society, interpersonal relations and basic value systems and their outlook on life have all been profoundly and adversely affected by the violence and destruction that has been a constant part of their daily existence. The war has, in fact, rendered virtually all young Lebanese "children in especially difficult circumstances".

PROGRAMME COOPERATION, 1990-1991

10. Since the outbreak of war in 1975, UNICEF cooperation has been in the form of emergency assistance programmes. With the breakdown of the Government at the central level, recent activities were more often than not undertaken without the benefit of any overall plan or objective situation analysis other than those which UNICEF attempted to draw up under what can only be described as extremely difficult circumstances. During the last two emergency programmes of assistance, 1988-1991, activities were directed at maintaining immunization levels, ensuring the regular supply of essential drugs, repairing and extending the water supply network, improving the physical condition of primary schools and organizing peace camps.

Health

11. The essential drugs programme began in 1989 and over 700 dispensaries are currently supplied and their personnel trained three times a year in the rational use of essential drugs and in preventive health care. A nationwide storage, distribution and monitoring system has been developed. A manual of essential drugs for mothers and children has been prepared in Arabic and 2,500 copies have been distributed to physicians and health workers. More than 80,000 patients per month benefit from the services. Initial attempts at a cost-recovery programme were dropped owing to the resurgence of fighting and the dire economic situation. Preventive health-care services continued with vaccination, diarrhoeal disease case management and health education activities operating through the vast majority of dispensaries. The expanded programme on immunization (EPI) was launched in 1987 and channelled through a network of 560 fixed dispensaries and health centres and 15 mobile teams, covering the whole country.

12. A national survey carried out in February 1991 indicated coverage levels for children under one year old for both oral polio vaccine (OPV) and three doses of combined diphtheria/pertussis/tetanus vaccine (DPT3) at over

80 per cent. Measles coverage, however, was significantly lower, with only 39 per cent of infants being immunized by their first birthday. This is due in part to the absence of an agreed schedule as to when the antigens should be given. Recent advocacy efforts by UNICEF have resulted in the professional associations of doctors in Lebanon formally adopting the WHO/UNICEF-recommended schedule.

13. The control of diarrhoeal diseases (CDD) project started in 1989 and 24 training sessions have been held for over 750 health personnel and 480 doctors. In addition, over 300,000 sachets of oral rehydration salts (ORS) have been distributed to health facilities to ensure their availability at the local level. In order to increase mothers' knowledge, health messages on the prevention and treatment of diarrhoea and associated feeding practices have been broadcast regularly on radio and television. As part of the health information system, sentinel reporting stations have been established at eight dispensaries and seven hospitals.

14. In 1991, UNICEF and the American University of Beirut undertook a national breast-feeding survey, the results of which were presented at a national conference for the medical profession, academics, civil servants and politicians. This activity was reinforced by articles in medical journals. As a result, the promotion of breast-feeding and safe weaning practices is being integrated into the curricula of medical and nursing schools as a prelude to the promotion of "baby-friendly" environments in maternity wards and clinics. Another direct result of these activities was the passing of legislation to ban the free distribution of infant formula to maternity clinics and hospitals.

Water supply and sanitation

15. In the area of water supply and sanitation, major repairs were made to the Beirut water supply water system, including the rehabilitation and equipping of two deep wells to provide the main lines with additional capacity. Sizeable water supply projects were implemented outside the Beirut area in conflict zones and in regions with displaced populations. In addition, 62 water tanks were installed to supply an estimated population of 400,000 in the suburbs of Beirut. Over 7,000 sanitation cleaning kits were distributed to families and repairs of sanitary facilities were undertaken. UNICEF also developed an emergency response capacity to detect contamination in water supplies and to provide, as a temporary measure, water tanks and chlorine. This response capacity was used successfully to combat four major epidemics of water-borne diseases, including cholera in 1990, and has been instrumental in containing outbreaks in 1991. As an extension of this emergency work, a nationwide survey of water quality was undertaken, which resulted in an institutional agreement between the American University of Beirut and the National Research Council to provide water-quality monitoring services for the Ministries of Health and Hydraulic and Electrical Resources.

Education

16. The education-for-peace project has reached over 100,000 children since 1989 with the assistance of 240 NGOs. Aimed at teaching positive values and attitudes to children through active learning processes, the project has generated interest in Lebanon and elsewhere for its innovative approach. Although originally started without an active government partner, it has now been adopted by the Ministry of Education. The project involved the training of 5,000 young people as animators in basic leadership skills for promoting peace values. Another important initiative in non-formal education is the children's magazine Sawa. Sawa, which means literally "together", is designed to promote the themes of unity, hope and peace among its readers. Distributed through health dispensaries, 70,000 copies of each issue reach 8- to 12-year-olds throughout the country. So far, 13 issues have been distributed. A review of the content of the 35,000 letters received from young readers indicates that the magazine is achieving its objectives.

17. Past UNICEF involvement in basic education has focused primarily on developing the health education curriculum and related resource materials for primary schools. Since 1987, the project has produced numerous textbooks and training materials and provided training for 1,300 health educators and 80 supervisors. Six health education centres have also been established.

18. Because of the security situation in Lebanon formal evaluations of the emergency assistance programmes have not been undertaken, but a number of in-house informal reviews have permitted revisions to be made to the current programmes and the future direction of the country programme to be influenced. It has been evident that, despite the complex emergency, it is possible to plan and undertake development activities such as peace education. Social mobilization and advocacy to promote programmes for children have also proven to be effective even in conflict situations. Some important features of past cooperation to be incorporated in future activities include using NGO grass-roots delivery expertise and focusing on activities at the community and district levels to empower communities, increase their participation and ensure sustainability.

19. Emerging from a prolonged civil war, Lebanon's national priority is to assess the country's needs and to develop appropriate strategies and plans for reconstruction and rehabilitation. At the same time, the Government of Lebanon has ratified the United Nations Convention on the Rights of the Child and has signed the World Summit for Children Declaration and Plan of Action, thus recognizing the need to give due importance to children's issues in its reconstruction and development plans. With the agreement of the Council for Development and Reconstruction, UNICEF has worked with the Government to prepare a programme of cooperation designed to ensure that Lebanese children develop their intellectual, social and physical capacities as an integral part of rebuilding for peace. The needs and priorities of the programme were included in the report of the United Nations inter-agency needs assessment mission to Lebanon in July 1991.

RECOMMENDED PROGRAMME COOPERATION, 1992-1996

Recommended general resources: \$ 5,000,000
Supplementary funding: \$20,000,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	<u>General resources</u>	<u>Supplementary funds b/</u>	<u>Total</u>
Primary health care	2 200	4 450	6 650
Water supply and sanitation	1 000	6 200	7 200
Education	1 100	9 350	10 450
Planning, advocacy and evaluation	<u>700</u>	<u>-</u>	<u>700</u>
Total	<u>5 000</u>	<u>20 000</u>	<u>25 000</u>

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Programme goals and objectives

20. The 1992-1996 programme of cooperation aims to help the Government of Lebanon achieve the following goals and objectives: (a) to reduce IMR from 35 to 28 per 1,000 live births and USMR from 43 to 34 per 1,000 live births by 1996; (b) to increase access by the rural and peri-urban population to safe drinking water and sanitary means of human excreta disposal; (c) to promote the creation of a lasting culture of peaceful coexistence and mutual understanding to replace the culture of war and violence; (d) to ensure universal access to a minimum level of basic education, including early childhood development, of a quality and content appropriate for the children of Lebanon; and (e) to plan, advocate and monitor progress towards the agreed goals for children in the 1990s.

Programme strategy

21. In all sectors where programme assistance is proposed, the following have been identified as being essential strategies: (a) the development of baseline data for planning interventions and the monitoring of their impact; (b) the empowerment of women by informing them how they can best meet the

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development needs of themselves and their children; (c) the development of national capacity to plan and monitor social services for children and women; and (d) the promotion of inter-agency cooperation to maximize the value of private sector, non-governmental and external contributions towards the attainment of the 1990 goals for children. UNICEF will redirect assistance away from emergency interventions towards a more structured plan of cooperation.

Primary health care

22. The PHC programme will consist of five projects: essential drugs; maternal and child health (MCH); EPI; ARI; iodine deficiency disorders (IDD); and CDD.

23. The objective of the essential drugs project will be to provide the foundation for a community-based and self-sustaining system of PHC delivery. Essential drugs will be supplied initially free of charge pending the development of a cost-recovery system. Activities will include support to PHC policy development, training of PHC personnel, supply of essential drugs and equipment and monitoring and evaluation of services.

24. The MCH project will aim (a) to increase the number of prenatal and post-natal consultations for mothers to three and five, respectively; (b) to achieve a rate of 90 per cent of mothers breast-feeding in each district and increase the rate of exclusive breast-feeding for four months to 25 per cent; and (c) to establish a national growth-monitoring system for children under five years old. Activities will include the training of PHC personnel and the equipping of centres to increase access to and the quality of perinatal, family planning and referral services; and the promotion of breast-feeding, with emphasis on "baby-friendly" environments and implementation of the government regulations on infant formula, processed weaning foods and milk substitutes.

25. The EPI objectives will be (a) to achieve and maintain a coverage rate of 90 per cent for OPV/DPT3; (b) to increase measles vaccination coverage from 40 to 80 per cent of children under one year old by 1993; (c) to reduce measles-related U5MR from 3 to 1 per 1,000 children by 1996; (d) to eradicate poliomyelitis by 1996; and (e) to eliminate neonatal tetanus by 1996. Immunization will be fully integrated into the PHC delivery system. Advocacy will focus on adequate national budget allocations for immunization and the use of uniform immunization schedules.

26. The CDD project will aim at reducing the following: (a) diarrhoeal disease-related U5MR from 1.3 to less than 1 per 1,000 live births; (b) the incidence of diarrhoea in children under five years old from 3.6 episodes per annum to less than 3; and (c) the percentage of cases treated with anti-diarrhoeal drugs from 61 to 30 per cent. Training on diarrhoea prevention and case management will be given to PHC personnel, school health supervisors and education-for-peace animators.

27. A survey on the prevalence of IDD will be conducted in 1992 and an appropriate strategy for their elimination will be developed.

Water supply and sanitation

28. The objectives of the programme will be to ensure that 80 per cent of rural and peri-urban communities have access to a minimum of 60 litres of safe water per person per day and to sanitary means of human excreta disposal. Technical assistance will be given to build national capacity for the planning of water and sanitation activities and the development of appropriate low-cost excreta disposal systems. Support will be provided to rural and peri-urban communities where the available level of safe drinking water is below the programme target, where the beneficiary community is prepared to make a major investment in capital costs and where a formal agreement will be made between the community and the local water authority on the financing of recurrent costs. The extension of the water quality control system will build on the existing arrangement between UNICEF, the American University of Beirut and the National Research Council. Social mobilization, communication and interlinking with other programme components will be important.

Education

29. The education programme will comprise (a) education for peace; (b) primary education; and (c) early childhood education.

30. The objectives of the education-for-peace project will be (a) to involve over 75 per cent of 6- to 15-year-olds in education-for-peace activities by 1996; (b) to improve access to non-formal education for life-oriented skills; and (c) to equip all youth leaders, teachers and social workers with techniques to promote peace values and conflict resolution. The project will build on the established alliance of NGOs and their team of trained youth leaders to continue peace camps and community activities. The dissemination of knowledge and messages directly to children will continue through Sawa magazine. Activities will include the training of trainers, seminars and workshops, and the development and production of resource materials.

31. The objectives of the primary education project will be (a) to achieve a sustainable primary school enrolment rate of 95 per cent; (b) to ensure that over 90 per cent of children under 11 years old complete their primary education; (c) to reduce the number of unqualified staff in primary education from 50 to 25 per cent; and (d) to increase the relevance of primary school curricula to present needs. Advocacy activities will focus on compulsory completion of the primary education cycle. Training will be given to 200 teacher trainers, 5,000 primary school teachers and 865 school principals. Assistance will be given to incorporate life-oriented skills, peace values, health education, communication skills and environmental topics into primary school programmes.

32. Support will be given to innovative and appropriate low-cost family and community-based early childhood development activities. An educational package on health, nutrition and early childhood stimulation will be developed and disseminated through the community, institutions and the mass media. In addition, support will be given to selected NGOs for the production of Arabic language educational materials. Advocacy efforts will focus on the enactment of a well-defined policy for early childhood development with realistically enforceable standards for child-care institutions.

Planning, advocacy and evaluation

33. This programme aims to help the Government of Lebanon and other partners to undertake the planning, advocacy and assessment activities required to achieve the 1990 goals to which the Government has subscribed. Use will be made of both governmental and private national institutions for conducting essential national research to support programme development and implementation. Existing alliances with parliamentarians, religious leaders, NGOs and the mass media to promote the ethic of a "first call for children" will be reinforced.

34. Advocacy and social mobilization will be fully integrated into sectoral programmes where the target audience is the community. Over and above these activities, support will be given to the parliamentary committee that monitors implementation of the Convention on the Rights of the Child and progress towards the 1990 goals. Orientation will be provided to NGOs seeking to contribute to the development and execution of government policies and plans. This will include advocacy support to those NGOs working in specialized fields of assistance for children such as orphans and the handicapped.

35. Major evaluations of the peace education project and the PHC and water supply and sanitation programmes will be conducted before the mid-term review to be held in 1994.

Cooperation with other United Nations agencies

36. UNICEF will continue to cooperate with the United Nations agencies in Lebanon. Specific areas of cooperation with UNDP will include the coordination of efforts in the area of women's development, education for all, and water supply and environmental sanitation. With WHO, plans of action will be prepared jointly for areas related to child survival and health. UNICEF will cooperate with the United Nations Educational, Scientific and Cultural Organization (UNESCO), UNDP and the World Bank in activities for achieving education for all in Lebanon by the year 2000. The United Nations Population Fund (UNFPA), WHO and UNICEF will jointly support safe motherhood practices and family health activities. UNICEF will cooperate with the Food and Agriculture Organization of the United Nations (FAO) and the World Food Programme (WFP) in the areas of child nutrition and food security. UNICEF will also meet regularly with bilateral agencies and national and international NGOs for exchanges of information and experience.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Lebanon		(1990 and earlier years)	UNICEF country classification	
Under-five mortality rate	56	(1990)	Middle USMR	
Infant mortality rate	44	(1990)	Middle IMR	
GNP per capita	\$ 2150	(1987)	Upper-middle GNP	
Total population	2701.0 Thousands	(1990)		

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1990
Births	(thousands)	87	81	80	86
Infant deaths (under 1)	(thousands)	4	4	4	4
Under-five deaths	(thousands)	6	5	5	5
Under-five mortality rate		65	62	57	56
(per 1,000 live births)					
Infant mortality rate (under 1)		50	48	48	44
(per 1,000 live births)					

		About 1980	Most recent
Underweight children (under 5)	Moderate & severe	..	..
(% weight for age)	Severe	..	..
Babies with low birth weight		12	10
(%, 1979/1983)			
% of primary school children		66*	..
reaching final grade (1980)			

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months		50*/ 40*/ 15*	/..
(%, 1980)			
Prevalence of wasting (%)		..	..
Prevalence of stunting (%)		..	..
Daily per capita calorie supply			
(% of requirements, 1979-1981/1988)		121	125
Food production per capita index		..	..
(Index 1979-1981=100, 1980/1990)			
Household expenditure	All food/cereals		/..
(% of total income, 1980-1985)			

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1988-1989)			10
Access to health services	Total	..	..
(% of population)	Urban/rural	.. /..	/..
Access to safe water	Total	92*	..
(% of population, 1980)	Urban/rural	95*/85*	/..
Access to adequate sanitation	Total	..	..
(% of population)	Urban/rural	.. /..	/..
Births attended by trained personnel		..	..
(%)			
Maternal mortality rate			
(per 100,000 live births)		..	..

Immunization		1981	1985	1990
One-year-olds (%) immunized against:	Tuberculosis	..	4	..
	DPT	..	60	82
	Polio	..	60	82
	Measles	..	23	39
Pregnant women (%) immunized against	Tetanus	..	..	..

/...

TABLE 1 (continued)

Lebanon

EDUCATION INDICATORS		About 1980	Most recent			
Primary enrolment ratio (gross/net) (%, 1980/1986)	Total	111 / ..	125/ ..			
	Male	.. / ..	105/ ..			
	Female	.. / ..	95/ ..			
Secondary enrolment ratio (gross/net) (%, 1980/1986)	Total	59 / ..	66/ ..			
	Male	.. / ..	57/ ..			
	Female	.. / ..	56/ ..			
Adult literacy rate, 15 years & older (%, 1970/1990)	Total	69g	80			
	Male/female	79g/ 58g	88/ 73			
Radio/television sets (per 1,000 population, 1980/1988)		749 /281	773/302			
DEMOGRAPHIC INDICATORS		1970	1980	1985	1990	2000**
Total population	(Thousands)	2469.0	2669.0	2668.0	2701.0	3327.0
Population aged 0-15 years	(Thousands)	..	1138.4	1067.6	1032.5	1251.8
Population aged 0-4 years	(Thousands)	..	345.2	342.1	383.8	405.1
Urban population (% of total)		59	76	80	84	87
Life expectancy at birth (years)	Total	64	65	65	66	69
	Male	62	63	63	64	67
	Female	66	67	67	68	71
Total fertility rate		5.5	4.0	3.8	3.6	2.9
Crude birth rate (per 1,000 population)		35	30	31	31	25
Crude death rate (per 1,000 population)		11	9	9	8	7
		About 1980		Most recent		
Contraceptive prevalence rate (%, 1971)		55		..		
Population annual growth rate (%, 1965-1980/1980-1990)	Total	1.6		0.1		
	Urban	4.6		1.1		
ECONOMIC INDICATORS		About 1980		Most recent		
GNP per capita annual growth rate (%, 1965-1980)		..		..		
Inflation rate (%, 1965-1980)		9		..		
Population in absolute poverty (%)	Urban/rural	../..		../ ..		
Household income share (%)	Top 20%/bottom 40%	../ ..		../ ..		
Government expenditure (% of total expenditure)	Health/education	../ ..		../ ..		
	Defence	..		..		
Household expenditure (% of total income)	Health/education			../..		
Official development assistance: (1980/1989)	US\$ millions	237		132		
Debt service (% of goods & services exports)	As % of GNP	..		..		
		..		..		

g/ Aged 10+.

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

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TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1990-1991

(In thousands of United States dollars)

COUNTRY: LEBANON

LATEST BOARD APPROVAL: 1990

GENERAL RESOURCES: \$1,000,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	438	1293	8	45	173	234	218	167	837	1739	2576
Water supply and sanitation	8	208			18	18		701	26	927	953
Education	125	55	65	153	147	167	150	804	487	1179	1666
Emergency		43								43	43
GRAND TOTAL	571	1599	73	198	338	419	368	1672	1350	3888	5238

GR = General resources.

FSF = Funded supplementary funding.

TABLE 3. PLANNED EXPENDITURE, 1992-1996

(In thousands of United States dollars)

Country: LEBANON Period covered: 1992-1996	Funding status	1992	1993	1994	1995	1996	Total
Health	GR	440	440	440	440	440	2200
	FSF	253					253
	NSF	890	890	890	890	890	4450
Water supply and sanitation	GR	200	200	200	200	200	1000
	NSF	1240	1240	1240	1240	1240	6200
Education	GR	220	220	220	220	220	1100
	FSF	210					210
	NSF	1870	1870	1870	1870	1870	9350
Planning, advocacy and evaluation	GR	140	140	140	140	140	700
TOTAL	GR	1000	1000	1000	1000	1000	5000
	FSF	463					463
	NSF	4000	4000	4000	4000	4000	20000
GRAND TOTAL		5463	5000	5000	5000	5000	25463

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: LEBANON	Number of posts	Amount (Thousands of United States dollars)
FINANCED FROM 1992-1993 APPROVED BUDGET:		
International Professional established posts	1	252
Local national Professional and General Service established posts	8	228
Operating costs		337
Total	9	817
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	1	226
Supplementary funds		
Local national Professional and General Service project posts		
General resources	15	377
Supplementary funds	31	879
Total	47	1482

a/ For information source, see the 1992 revised post authorization table,
dated 23 July 1991.



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Programme Committee
1992 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Morocco

The Executive Director recommends that the Executive Board approve the country programme of Morocco for the period 1992 to 1996 in the amount of \$13,200,000 from general resources, subject to availability of funds, and \$11,800,000 in supplementary funds, subject to the availability of specific-purpose contributions.

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* In order to meet documentation deadlines, this document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1991, will be contained in the "Summary of 1992 recommendations for general resources and supplementary funding programmes" (E/ICEF/1992/P/L.2 and Add.1).

THE SITUATION OF CHILDREN AND WOMEN

1. The population of Morocco is estimated at nearly 26 million and, at a natural annual growth rate of 2.6 per cent, it is expected to double roughly every 25 years. The population is characterized by its youth - 40 per cent of the total population is under 15, 51 per cent is under 20. Fertility has declined noticeably since the beginning of the 1960s; the female fertility rate dropped from 7.2 in 1962, to 5.7 in 1982 and to 4.5 in 1987, representing a decline of nearly 38 per cent in 25 years. The decline is more pronounced in urban areas than in rural areas. For economic reasons, almost 50 per cent of the population is concentrated in two regions, the Centre and the North-west. Rapid urbanization will raise the urban population from 46.5 per cent in 1991 to 51.2 per cent of the total population by the year 2000 (Ministry of Planning).

2. The Moroccan economy remains subject to many limitations. In 1990, the outstanding external debt represented almost 90 per cent of the gross domestic product (GDP), placing a serious strain on the country's financing capacity and limiting its development financing resources. According to the estimates of the Ministry of Planning, the urban unemployment rate in 1990 was 15.8 per cent: 14.2 per cent for men and 20.4 per cent for women. Unemployment is found even among those who have diplomas. A national survey conducted in 1991 by the National Council for Youth and the Future counted 100,374 such people (high-school graduates, university graduates and technicians) seeking jobs. Moreover, Morocco was particularly affected by the situation between Iraq and Kuwait which had a negative impact on port traffic, tourism and related sectors such as transport, handicrafts and the hotel industry. The loss of Iraq and Kuwait as suppliers of oil at preferential prices further burdens the balance of payments.

3. Over the past 20 years, Morocco has experienced a significant decline in mortality among children under five. Since 1962, the infant and child mortality rate has dropped by 50 per cent and the infant mortality rate (IMR) by 38 per cent, with neonatal mortality falling by 29 per cent. According to recent surveys the infant and child mortality rates are 73 per 1,000 live births and 102 per 1,000 respectively. Expansion and acceleration of the National Immunization Programme has helped to improve the situation and reduce the incidence of target diseases. Despite these significant and encouraging results, however, infant and child mortality rates remain extremely high, with major disparities from one region and area to another.

4. Diarrhoeal disease is the leading cause of death in children under the age of five (39 per cent), followed by infectious diseases (22 per cent) and acute respiratory infections (ARI) (14 per cent). Malnutrition is a factor in at least 22 per cent of cases. The incidence of delayed growth and low weight in this age group remains high, 20 per cent and 28.2 per cent respectively (Ministry of Public Health (MSP)/UNICEF, 1990). Furthermore, iodine deficiency disorders have been noted, in the mountainous areas in particular (for example, the incidence of goitre reaches an average of 65 per cent in Azilal province).

/...

5. The maternal mortality rate is high - between 300 and 585 per 100,000 live births according to sources (MSP/World Bank). A current concern is to determine the exact situation with regard to maternal mortality, its causes and existing disparities. Currently, the leading causes are believed to stem from medical-obstetrical problems, pregnancy when the women is too young or too old, lack of pre-natal care (74 per cent of cases) and conditions of delivery (only 6 per cent of deliveries are attended by a doctor and 20 per cent by a nurse or midwife).

6. Since independence, education has been a major priority in Morocco's development policy. The share of the State budget allocated to education has grown from 17 per cent in 1961 to more than 23 per cent in 1988. Progress has undeniably been achieved: between 1961 and 1989, primary school enrolment more than doubled, increasing by 2.5, and the rate of enrolment for 7-year-olds grew from 13 per cent in 1960 to almost 67 per cent in 1990. However, these results still fall short of the goals set in the various development plans. The school dropout rate remains high and varies tremendously from one province to another (ranging from 24 per cent to 98.7 per cent). The rate of school enrolment among girls remains far below the national average, especially in rural areas, no more than 36.7 per cent in 1990 (Ministry of Education). Illiteracy remains widespread among young people and is even greater in rural areas. Among women, illiteracy is especially high; according to the 1982 census, 95 per cent of rural women and 57 per cent of urban women are illiterate.

7. With regard to water supply, 76 per cent of the urban population has access to running water in the household, while 24 per cent gets its water from standpipes. In rural areas, the percentages are 2 per cent and 20 per cent, respectively. The rest of the population gets its water - which is often of doubtful quality - from a variety of sources (springs, wells, wadis, cisterns, irrigation ditches). Sanitation facilities are extremely rare. It is estimated that close to three fourths of rural villages and 69 per cent of the urban population have no sanitation system. In 83 per cent of rural villages, women and children fetch the drinking water, spending from 2 to 4 hours each day to get about 80 litres of water.

8. The issue of children and women in urban fringe areas is becoming of increasing concern. Rapid urbanization has led to a proliferation of shantytowns where basic services (health, education, water and sanitation) are in scanty supply. According to surveys conducted in 1990 (Moroccan Child Protection League/UNICEF) there are several categories of children in especially difficult circumstances (children without families, street children, working children, etc.).

9. In Morocco women as a social group have lagged behind others where development is concerned. It is true that, since independence, women have experienced many changes, both quantitative and qualitative but although they make up 51.1 per cent of the population, do not have equal access to education, particularly in rural areas. So far as their status is concerned, women do not yet enjoy sufficient protection under the law.

PROGRAMME COOPERATION, 1987-1991

10. The programme of cooperation for the period 1987-1991 sought to reduce infant and child mortality through actions such as immunization and the control of diarrhoeal disease (CDD) and efforts to improve basic services. The components of the programme were as follows: health and nutrition; water and sanitation; education; and women in development.

Health and nutrition

11. During that five-year period, cooperation with the Government developed at an unprecedented rate through the activities carried out in the area of immunization. The national programme of immunization had spectacular results and the objective of universal immunization was achieved as a result of the tremendous expansion of the programme after 1987.

12. Benefiting from the personal support of the Head of State and the royal family, successive immunization campaigns were organized, backed by a high level of social mobilization. The permanent programme was strengthened; the number of immunization centres doubled; 2,000 itinerant health workers participated in immunization activities; and the planning and management of the activities were decentralized. This success transcended frontiers since the heads of State of other Maghreb countries supported the Moroccan initiative and decided to designate 14 October as Maghreb immunization day. The assistance provided by UNICEF helped to ensure a steady supply of vaccines, to increase cold chain capacity to develop human resources, to strengthen logistical and monitoring resources, and also information, education and communication (IEC).

13. According to the 1991 cluster survey (MPH/UNICEF) immunization coverage (each antigen) among children under the age of one is over 90 per cent and among women of child-bearing age, in respect of the anti-tetanus vaccine (ATV), it is 64 per cent. The Government is now trying to work out an alternative strategy which would achieve the same results at a lower cost, particularly as regards the immunization of women against tetanus. Despite the improvement in the performance of the permanent programme, 37 per cent of women are immunized only during campaigns.

14. With regard to CDD, UNICEF concentrated its assistance on training health personnel, health education, monitoring, operational research and supplying packets of oral rehydration salts (ORS). The Ministry of Public Health organized national and provincial campaigns to promote oral rehydration therapy but this did not suffice to achieve all the desired results. The project slowed down somewhat due to implementation problems and poor performance of the programme generally, as well as to technical factors related, in part, to difficulties in producing ORS packets locally. UNICEF provided over 5 million packets, which helped, inter alia, to alleviate the problems resulting from the shut-down of the production factory. Assistance was sought from other partners, including the private sector, and this offers better prospects for the project, which remains a public health priority.

15. To promote maternal and child health, the activities undertaken concentrated on growth monitoring and nutrition. Special emphasis was placed on the promotion of breast-feeding, weaning, personal hygiene and food hygiene. Messages from Facts for Life concerning maternal and child nutrition were widely disseminated. UNICEF support made it possible to provide baby scales, supplies and equipment for health centres and medical kits for midwives; a training manual was prepared for traditional birth attendants. However, inaccessibility of health services for a large part of the population has continued to hamper the project. In view of the situation, UNICEF helped conduct an experiment for drawing up a plan to extend health coverage for some poorly served districts. The lessons drawn from this experiment are regarded as a significant contribution to improved quality of care and better planning of health resources.

Water and sanitation

16. The efforts undertaken were designed to support and supplement the drinking water supply activities that had been initiated and implemented by local communities in rural areas. The objective was also to develop community participation in water activities. The UNICEF contribution consisted of training and technical assistance, supply of materials and equipment, and logistical resources. In this context, over 200 manual pumps were installed; the pump heads, for the most part, were manufactured locally. Water points were equipped with pumping systems (solar, wind, motor and electric pumps). These installations corresponded to 84 per cent and 96 per cent, respectively, of the initial objectives.

17. The sanitation and hygiene activities did not follow on after the water supply activities because they were carried out outside project areas, and this limited their impact. The programme had to be refocused so as to progress from purely technical aspects to activities to improve the quality of the services delivered. Thus, collective modified latrine units were introduced in rural schools and biogas compacters were built for demonstration purposes. Moreover, 60 engineers and technicians were trained - they now constitute the provincial maintenance teams - and health information and education activities were organized around water points. The programme was adversely affected, however, by the low capacity of provincial services in respect of planning, project identification and programming.

Education

18. The activities envisaged for the programme were as follows:
(a) restructuring and adaptation of traditional Koranic pre-school teaching to meet the educational and development needs of the child; (b) incorporation of health and nutritional education in primary education; (c) launching of pilot projects for the functional literacy of women; (d) contribution to the establishment of a unit to train specialized teachers to care for handicapped children. Thus, 350 teaching advisers were trained to supervise schools and provide group orientation for the fugaha' (teachers in Koranic schools), who were also trained in early learning and stimulating activities for young

children. A teaching manual was prepared as a reference work for the fugaha' and also a specific guide on health. However, an in-depth evaluation of the activities has been found necessary because of the obstacles encountered: the large number of participants, the content of teaching, the scattered locations of Koranic schools, the limited participation by girls, and the low levels of pay of the fugaha'. In respect of primary education, the health and nutrition component was introduced in official primary education programmes. UNICEF helped the Government develop a set of teaching modules for teacher and student at the first six levels. In order to promote the use of these modules in all the provinces of the Kingdom, information and training sessions were organized for school principals.

Advancement of women

19. The objectives of this programme were: (a) to increase food supplies at the family level by providing technical and financial support for rural women; (b) to disseminate information on health, hygiene and nutrition to women in rural and urban fringe areas; (c) to promote schooling for girls in rural areas. To this end, several training sessions were held for agricultural extension workers on varied subjects such as: livestock rearing, bee-keeping, market gardening, communication techniques, farm management and biogas. Training days in the fields of health, family planning, literacy and manual work were organized for 350 female instructors in women's centres. Studies were carried out on the situation of women to identify the provinces where their situation is most critical, for example Chefchaouen (UNICEF, 1990). Training and awareness campaigns were carried out regarding the importance of schooling for girls. However, the activities undertaken are still very limited. The problems of "women in development" therefore remain.

Advocacy

20. Sustained advocacy efforts were undertaken as support for the programme, particularly in the field of immunization, using modern communications facilities (radio and television) and traditional methods such as folklore troupes, asuaq (souks) (covered markets) and mauasim (seasonal festivals). Special emphasis was placed on the Convention on the Rights of the Child and on activities relating to the World Summit for Children and the Plan of Action which resulted from it. Advocacy for girls with decision makers and influential bodies was intensified. In May 1991, a Maghreb symposium entitled "Girls too", organized under the auspices of the Moroccan Association for UNICEF (AMS) in cooperation with UNICEF, brought together researchers from the countries concerned to consider the specific problems impeding the development of girls, to make decision makers aware of the importance of the issue and to formulate recommendations that can be implemented throughout the Maghreb.

Lessons drawn from previous experience

21. Past cooperation concentrated on universal child immunization and much has been learned from that experience. In particular, it has shown that the country is able to mobilize for child health, and also to set objectives and

to achieve them. The political will that was demonstrated, the networks that were established with non-governmental organizations (NGOs) and associations, and good media coverage have created a favourable environment for the acceleration of future activities to benefit children. Similarly, the experience acquired in the expanded programme on immunization (EPI) will be put to use in systematically carrying out "packages" of activities to benefit children and women, particularly in respect of diarrhoeal disease, promotion of maternal health and other sectoral programmes.

22. Disparities persist between the sexes and between regions as regards coverage of basic services; it is therefore necessary to protect social sectors from the impact of structural adjustment measures. New problems are appearing in urban fringe areas and they require particular attention. Activities will certainly be necessary at the national level, but it would be wise to concentrate efforts on priority geographical areas so as to maximize impact, reduce disparities and carry out integrated activities to ensure greater family participation. In this respect, water supply activities would serve as a point of entry and a catalyst for integration in rural areas. This will involve implementing the recommendations of the evaluation of the Ministry of the Interior/UNICEF (1990) and bringing systems more into line with the need of users, particularly women and children.

RECOMMENDED PROGRAMME COOPERATION, 1992-1996

General resources: \$13,200,000
Supplementary funds: \$11,800,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	<u>General resources</u>	<u>Supplementary funds b/</u>	<u>Total</u>
Basic health	6 030	6 750	12 780
Education	545	500	1 045
Integrated basic services in rural areas	4 975	4 050	9 025
Children in difficult circumstances in urban fringe areas	400	500	900
Planning, social mobilization and advocacy	<u>1 250</u>	<u>-</u>	<u>1 250</u>
<u>Total</u>	<u>13 200</u>	<u>11 800</u>	<u>25 000</u>

a/ The breakdown for estimated yearly expenditures is given in table 3 below.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

/...

Preparation of the programme

23. The principles to be observed in implementing this country programme were established in the light of: priority problems of children and women revealed by the situation analysis; lessons learnt from previous cooperation (1987-1991); priorities of the Government's economic and social policy relating to children and women; the Convention on the Rights of the Child; the World Declaration and the Plan of Action for Implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s; UNICEF's medium-term plan for 1991-1993; and cooperation with multilateral and bilateral organizations and with NGOs.

Purposes and objectives

24. The Government is preparing a new five-year economic and social development plan for the period 1993-1997, the broad lines of which coincide with the purposes and objectives of the World Summit. This cooperation programme is part of those efforts and supports the following objectives: (a) placing and maintaining children on the political agenda and among the top political priorities of national development; (b) reducing the IMR, estimated at 73 per 1,000 live births, by one quarter by 1996; (c) reducing the child mortality rate, estimated at 102 per 1,000 live births, by one quarter by 1996; and (d) reducing the maternal mortality rate (MMR) by 10 per cent by 1996.

Programme strategy and components

25. The country programme will be implemented by means of a two-tier strategy to be applied at the national level and at the level of specific (rural and urban fringe) geographical areas. At all these levels, girls are to be the key theme running through the programme and equality of girls and boys is to be one of the main indicators of performance. At the national level, this will mean supporting the implementation of policies and the development of structures in the fields of health and education. IEC, social mobilization and advocacy have been treated as an integral part of all sectoral programmes. These programmes will also benefit from the improvement of planning capabilities and the strengthening of statistical structures relating to the situation of children, girls and women.

26. At a decentralized level, action is planned in very limited geographical areas with the aim of, on the one hand, reducing disparities between the provinces while optimizing assistance to target communities in rural areas and, on the other, helping to solve the problems encountered by particular categories of children in urban fringe areas. Integrated activities at community level will be developed and undertaken with the participation of community members, adopting a dynamic approach that will involve the beneficiaries in identifying their problems, seeking the most effective solutions and introducing mechanisms for the gradual recovery of costs. The lessons learned from such an approach may be turned to account in other areas. With that end in view, the 1992-1996 country programme is built around the five programmes described below.

Basic health

27. The basic health programme is organized around five projects based on an integrated primary health care (PHC) approach.

28. The objectives of the EPI project are as follows: (a) to achieve and maintain 95 per cent immunization coverage during the 1990s for children under one year of age; (b) to achieve 90 per cent immunization coverage for women of child-bearing age with at least two doses of anti-tetanus vaccine and to maintain that rate during the 1990s; (c) to eliminate neonatal tetanus as a cause of death by 1995; (d) to reduce the gross annual incidence of measles among children under one year of age from over 2,000 cases to less than 500 cases by the end of 1996, and to eliminate the illness as a cause of death. In addition, the EPI project supports the Government's aim of eradicating poliomyelitis by 1996. The Government and UNICEF, with the backing of Rotary International, have undertaken to ensure that the project is sustained and to consolidate the advances achieved. In this connection, an approach known as the "immunizational independence initiative" has been developed so that the Government can gradually take over responsibility for ensuring a steady supply of vaccines.

29. UNICEF's contribution will consist of technical assistance, strengthening of the cold chain and provision of injection and sterilization equipment. Epidemiological surveillance will be increased in order to identify the localize low-coverage and high-risk areas. To that end, emphasis will be placed on training personnel at the intermediary and peripheral levels and on improving and computerizing services at the central and provincial levels. Continued immunization work will make it easier to control ARI and will speed up action with respect to the other components of PHC.

30. The CDD project is designed to reduce mortality and morbidity related to diarrhoeal diseases by one quarter among the under-fives by 1996 and to promote prevention in this same area. Much of the project will consist of IEC, with special emphasis on home treatment, training and retraining. UNICEF will provide support for training courses in the form of practical programmes for health professionals and instruction in supervisory techniques for provincial officials. All fixed vaccination centres will gradually be provided with the requisite facilities (materials and equipment, staff) for proper handling cases of diarrhoeal disease. UNICEF will continue to supply packets of oral rehydration salts (ORS), while encouraging the Ministry of Public Health to develop local production capacities under optimum conditions. The IEC campaigns will form an integral part of water supply, hygiene and sanitation activities (integrated basic services in rural areas programme). Special attention will be given to the prevention of cholera. A mass breast-feeding campaign will be organized with the assistance of the United States Agency for International Development and national NGOs.

31. The aims of the ARI control project are: (a) to reduce deaths due to acute respiratory infections by 10 per cent among children under five years of age; (b) to reduce the severity of ARI among children and the attendant

serious complications; (c) to check the misuse of antibiotics and other drugs in the treatment of ARI among children. Action will focus on the development of human resources and each year a planning workshop, a training seminar for doctors and paramedical staff and an information meeting for private-sector doctors and pharmacists will be organized at the provincial level. Special attention will be given to the promotion of breast-feeding and to immunization against whooping cough and measles as support activities. UNICEF will supply the medicines needed to consolidate the initial phase of the project, and will strengthen planning and promote the introduction of appropriate practical procedures for handling cases in health establishments in the pilot regions.

32. The promotion of safe motherhood aims at achieving a 10 per cent reduction in MMR and a one third reduction in neonatal mortality by 1996. This will mean increasing the number and improving the quality of regular prenatal and postnatal check-ups, improving delivery conditions both at home and in medically supervised facilities and increasing the percentage of women receiving proper assistance during childbirth from 26 to 50 per cent. Support will focus on intensifying IEC activities in local communities and enhancing the capacity of maternity clinics.

33. UNICEF will assist in training birth attendants, supplying materials and equipment and following a study, making available appropriate means of evacuation (transport). The IEC activities will include education in the prevention of acquired immune deficiency syndrome (AIDS), in child growth and nutrition and in combating iron deficiency anaemia. The "baby-friendly hospitals" approach will be tested and introduced in a number of national hospitals and subsequently in maternity hospitals. The complexity of the problem calls for a gradual approach. Assistance will initially be provided to two provinces and then extended to two more before the end of the cycle. It will supplement the assistance being provided by other bodies such as the United Nations Population Fund (UNFPA), USAID and the World Health Organization (WHO).

34. The iodine deficiency project will involve the establishment by 1996 of facilities for the elimination of iodine deficiency disorders in Azilal, Taza, Chechaouën and Khenifa, the four provinces where the incidence of such disorders is high. Studies of the prevalence of goitre will be undertaken in those areas. UNICEF will support initiatives aimed at prevention through the provision of iodine supplements, which will evolve into an overall salt and/or water iodization strategy based on the socio-economic and geographical characteristics of the individual provinces.

Education

35. This programme forms part of the Government's programme to achieve universal basic education by the year 2000. With that in view, it is supporting the following national efforts: (a) to improve the quality of basic education; (b) to promote education for girls, particularly in rural areas; (c) to advocate that girls should remain at school at least throughout the period of basic education; (d) to promote early childhood development

within the family context, with the emphasis on parental responsibility and roles; (e) to strengthen local literacy skills; and (f) to encourage literacy among girls and young women. The main aim of the activities is to ensure that a health/nutrition component is included as a general principle in the basic education curriculum. Efforts will also be made to foster the role of the child as an "agent of development", who will transmit the knowledge acquired at school to parents, children and the community.

36. In this framework, UNICEF will continue to assist in devising educational documents, training educators at regional level in the use of the new curriculum and in organizing information days for heads of educational establishments. With regard to IEC, the programme will be based on the ideas set forth in Facts for Life and will seek to use the third channel to promote, at national level, early childhood development within the family context and to encourage education for girls as well as boys. The programme will receive assistance from other partners including the World Bank, the United Nations Development Programme (UNDP), the World Food Programme (WFP), the United Nations Educational, Scientific and Cultural Organization (UNESCO) and the United Nations Population Fund (UNFPA).

37. With regard to literacy, the aim is to include courses on literacy methodology and on adult education in the teacher-training curriculum and also to provide retraining for female literacy instructors in women's centres. Support will be given for training, the preparation of a guide for educators and a manual for women instructors, and for provision of teaching materials (audio-visual materials, documentation, etc.).

Integrated basic services in rural areas

38. One of the concerns of the country programme is to reduce the disparities between provinces with regard to child survival. Five provinces have been selected for the current programme, namely Chechaouèn and Tata (both already chosen for the iodine deficiency project), El Haouz, Ifrane and Taza. The selection was based on a series of indicators. In fact, the vast majority of the people of these five provinces live in rural areas, where scattered settlements, fragile infrastructure and isolation make life particularly difficult for women and children, to whom is left, almost exclusively, the chore of fetching water and collecting wood. These areas also have low school enrolment rates and very high IMR.

39. The programme was prepared in close collaboration with the central and provincial authorities and joint field trips were undertaken, making it possible to determine the field of action in each province. The target provinces have a population of almost 1 million, 35 per cent of whom will benefit directly from the programme.

40. The integrated basic services programme is designed to speed up social development in these areas by stimulating a vigorous demand for services capable of improving the situation of children and women, while at the same time mobilizing local resources, including those of the community, in order to

meet this demand. The programme is based on the development of local skills in the planning and management of community activities. The goals are to: (a) reduce infant and child mortality and morbidity rates by 30 per cent by 1996; (b) provide adequate access to drinking water, sanitation and hygiene for 300,000 inhabitants; (c) reduce the incidence of water-borne diseases; (d) alleviate the drudgery of fetching water for women and children; (e) increase preschool and school enrolment rates by more than 25 per cent from their current respective levels of 26 per cent and 66 per cent; (f) promote literacy among girls and women; (g) provide the guidance necessary to stimulate activities capable of generating substantial levels of income; and (h) broaden the knowledge of female agricultural extension workers and encourage women to play a leadership role. IEC is an integral part of this process. The programme will be implemented gradually. Initially, actions will be focused in two provinces and then extended in stages to the other provinces.

Children in difficult circumstances in urban fringe areas

41. The current programme seeks to facilitate access to basic services for disadvantaged children and their families in urban fringe areas. As this is Morocco's first experience with UNICEF assistance, the programme's objectives are confined to devising solutions to avert the problems faced by children in especially difficult circumstances in these areas and drawing on experience and research to identify suitable ways of assisting the most disadvantaged sectors of the population.

42. The programme will begin with the organization of a workshop bringing together operators familiar with the sector in order to determine the nature, scope and the location of problems and to identify dynamic groups among the community who can help carry out the activities. The programme will be implemented initially in the urban areas around Salé and later in the town of Fez. It will attempt to bring together the various aspects of child survival, particularly basic health, hygiene and sanitation, the strengthening of women's survival capacity (income), and improved formal and informal education. The experience gained will be used extensively for the purposes of advocacy and application in other areas.

Planning, social mobilization and advocacy

43. This programme provides opportunities for accelerating the different components of the present country programme. Its aims are to: (a) include and maintain children among the main priorities for national development policies and promote measures to assist them on a national scale; (b) extend and strengthen affiliation networks; and (c) help strengthen the capacity of statistical and planning structures. UNICEF will provide support for the preparation and dissemination of IEC equipment, training and awareness activities and for strengthening the use of computers for statistics and planning.

44. The ratification and implementation of the Convention on the Rights of the Child and the adoption and execution of the national action programme advocated by the World Summit for Children are priority objectives. With that in view, the Ministry of Social Affairs has been given responsibility for coordinating the national programme with the help of a technical committee which includes representatives from the other Ministries concerned. Within this specific framework, a monitoring unit and a data bank will be set up at the Ministry of Planning, in order to keep track of progress made in achieving the objective set for the 1990s.

Monitoring and evaluation

45. In the light of the experience already gained in the development of indicators, the Government and UNICEF have undertaken to consolidate existing systems (mechanisms for the gathering, analysis and dissemination of information) at national and provincial levels so as to monitor regularly the progress of the programme and measure its impact. Mid-term evaluations of the health programme (EPI/CDD/ARI), and of the iodine deficiency and integrated services programmes, are scheduled for 1993. These will provide the basis for a mid-term review to be held during the second quarter of 1994 to assess the implementation of the programme and make any necessary adjustments for the remainder of the cycle. Basic studies will be undertaken at national level for certain target diseases and at regional level to obtain basic data in the provinces covered by the integrated activities. Impact assessments are scheduled for 1996 for infant and child mortality and morbidity rates, including those related to the target diseases, as well as for the programme components relating to water and sanitation, education, and children in urban fringe areas. The programmes and projects will be monitored through field trips and annual reviews. The latter will make it possible to identify what studies and project evaluations are necessary and to prepare annual action plans. In addition, the priority accorded to global objectives, and more specifically to girls as a major beneficiary of the country programme, will also be reflected in the monitoring of indicators at central and provincial level and the establishment and development of a database on gender differences.

Programme management plan 1992-1996

46. A management plan has been drawn up for the implementation of the country programme. It analyses the structure of the programme and the way in which it has been designed, taking into account the order of priority of objectives and the link between objectives and the human and financial resources available for their attainment. The UNICEF office in Rabat has been restructured to make it more responsive to the requirements of the programme.

Collaboration with partners

47. Collaboration with multilateral and bilateral organizations, as well as with NGOs, will be pursued and extended with a view to achieving closer coordination of actions and optimum use of resources so as to achieve maximum

impact. In the field of health, the main partners will be WHO, UNFPA and USAID. In the field of education, UNESCO, WFP, UNFPA, UNDP, the World Bank and UNICEF will work together. Other partners will include the NGOs, notably the Moroccan Association for UNICEF (AMS) and the Moroccan Child Protection League.

Initiatives by the Maghreb countries

48. As they did with the Maghreb immunization days, which have now become a regular event, the five Maghreb countries will join forces in other areas, namely the status of girls; preschool education; promotion of safe motherhood; and children without families. Indicators will be devised to specifically monitor these areas of common concern, in order to promote and gauge the success of Maghreb initiatives. Morocco will continue to play a key role in promoting this regional approach, which offers greater scope for the effective application of measures to ensure the survival, development and protection of Maghreb children.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Morocco		(1990 and earlier years)		UNICEF country classification		
Under-five mortality rate	112	(1990)		High USMR		
Infant mortality rate	75	(1990)		High IMR		
GNP per capita	\$ 950	(1990)		Lower-middle GNP		
Total population	25.1 Million	(1990)				
KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT			1970	1980	1985	1990
Births	(thousands)		717	731	793	858
Infant deaths (under 1)	(thousands)		93	76	71	64
Under-five deaths	(thousands)		137	112	105	96
Under-five mortality rate			191	153	132	112
(per 1,000 live births)						
Infant mortality rate (under 1)			130	104	90	75
(per 1,000 live births)						
			About 1980		Most recent	
Underweight children (under 5)	Moderate & severe		..		16a/	
(% weight for age, 1980/1987)	Severe		5		4a/	
Babies with low birth weight			..		..	
(%, 1979/1987)						
% of primary school children			..		67	
reaching final grade (1980/1988)						
NUTRITION INDICATORS			About 1980		Most recent	
Mothers breast-feeding at 3/6/12 months			83/ 75/ 62		87 /77/59	
(%, 1980/1987)						
Prevalence of wasting (%, 1980/1987)			..		6	
Prevalence of stunting (%, 1980/1987)			..		34b/	
Daily per capita calorie supply						
(% of requirements, 1979-1981/1988)			114		117	
Food production per capita index			107		124	
(Index 1979-1981=100, 1980/1990)						
Household expenditure	All food/cereals				40*/12*	
(% of total income, 1987)						
HEALTH INDICATORS			About 1980		Most recent	
ORT use rate (%, 1989)					14	
Access to health services	Total		52		70	
(% of population, 1980/1985)	Urban/rural		93 / 24		100/ 50	
Access to safe water	Total		30*		61	
(% of population, 1980/1988)	Urban/rural		63*/ 2*		100/ 25	
Access to adequate sanitation	Total		..		..	
(% of population, 1985)	Urban/rural		.. /..		../ 16	
Births attended by trained personnel			29		26*	
(%, 1980/1990)						
Maternal mortality rate						
(per 100,000 live births, 1974)			300		..	
			About 1980		Most recent	
Immunization			1981	1985	1990	
One-year-olds (%) immunized against:	Tuberculosis		..	78	96	
	DPT		43	46	81	
	Polio		45	46	81	
	Measles		..	42	79	
Pregnant women (%) immunized against	Tetanus		..	..	64	

/...

TABLE 1 (continued)

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net) (%, 1980/1988)	Total	78/ 58	67/ 55
	Male	96/ 71	80/ 65
	Female	59/ 45	53/ 44
Secondary enrolment ratio (gross/net) (%, 1980/1988)	Total	25/ 20	36/ ..
	Male	32/ 24	43/ ..
	Female	19/ 15	30/ ..
Adult literacy rate, 15 years & older (%, 1970/1990)	Total	22	50
	Male/female	34/ 10	61/ 38
Radio/television sets (per 1,000 population, 1980/1988)		155/39	207/ 55 _{c/}

DEMOGRAPHIC INDICATORS		1970	1980	1985	1990	2000**
Total population	(Million)	15.3	19.4	22.0	25.1	31.6
Population aged 0-15 years	(Million)	..	8.8	9.7	10.7	12.3
Population aged 0-4 years	(Thousands)	..	3199.4	3413.7	3775.0	4036.9
Urban population (% of total)		35	41	44	48	55
Life expectancy at birth (years)	Total	52	57	59	62	67
	Male	50	55	58	60	65
	Female	53	59	61	64	69
Total fertility rate		7.0	5.7	5.1	4.5	3.3
Crude birth rate (per 1,000 population)		47	38	36	34	27
Crude death rate (per 1,000 population)		17	12	11	9	7

		About 1980	Most recent
Contraceptive prevalence rate (%, 1980/1987)		20	36
Population annual growth rate (%, 1965-1980/1980-1990)	Total	2.5	2.6
	Urban	4.2	4.1

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980/1980-1990)		2.7	1.6
Inflation rate (%, 1965-1980/1980-1989)		6	7
Population in absolute poverty	Urban/rural	28/ 45	../ ..
Household income share (%)	Top 20%/bottom 40%	../ ..	../ ..
Government expenditure (% of total expenditure, 1980/1987)	Health/education	3/ 17	3/ 17
	Defence	18	15
Household expenditure (% of total income, 1980-1985)	Health/education		3/ 6
Official development assistance: (1980/1989)	US\$ millions	894	443
Debt service (% of goods & services exports, 1980/1989)	As % of GNP	5	2
		27	26

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

a/ Aged 0-36 months.

b/ Aged 24-36 months.

c/ Licences only.

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TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1987-1991

(In thousands of United States dollars)

COUNTRY: MOROCCO
LATEST BOARD APPROVAL: 1987
GENERAL RESOURCES: \$9,020,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	4916	1520	131	70	110		1936	239	7093	1829	8922
Water supply and sanitation	1535	94	89		234		213	3	2071	97	2168
Nutrition	176		24		24		108		332		332
Education	101		184		186		241		712		712
Community organization and development	108		10				44		162		162
Women-centred programme	37		127		82		122		368		368
Children in especially difficult circumstances	57		9	5			21	32	87	37	124
Advocacy	5	5			107		27	1	139	6	145
Planning and project support	153				308		159	16	620	16	636
Freight	215	13					3		218	13	231
GRAND TOTAL	7303	1632	574	75	1051		2874	291	11802 a/	1998	13800

GR = General resources.

FSF = funded supplementary funding.

a/ Including allocations to fund unfunded supplementary funding and allocations from global funds.

TABLE 3. PLANNED EXPENDITURE, 1992-1996

(In thousands of United States dollars)

Country: MOROCCO Period covered: 1992-1996		Funding status	1992	1993	1994	1995	1996	Total
Health	GR		1185	1165	1215	1215	1250	6030
	FSF		98					98
	NSF		1350	1350	1450	1400	1200	6750
Education	GR		125	100	110	120	90	545
	NSF		100	120	90	80	110	500
Children in especially difficult circumstances	GR		80	80	100	90	50	400
	NSF		70	90	110	100	130	500
Planning and social mobilization	GR		270	290	220	230	240	1250
Integrated area-based programme	GR		980	1005	995	985	1010	4975
	FSF		140					140
	NSF		1260	755	770	330	935	4050
TOTAL	GR		2640	2640	2640	2640	2640	13200
	FSF		238					238
	NSF		2780	2315	2420	1910	2375	11800
GRAND TOTAL			5658	4955	5060	4550	5015	25238

GR = General resources.

NSF = New supplementary funding.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: MOROCCO	Number of posts	Amount (Thousands of United States dollars)

FINANCED FROM 1992-1993 APPROVED BUDGET:		
International Professional established posts	1	252
Local national Professional and General Service established posts	6	295
Operating costs		356

Total	7	903

FINANCED FROM PROGRAMME FUNDS: ^{a/}		
International Professional project posts		
General resources	1	226
Supplementary funds		
Local national Professional and General Service project posts		
General resources	9	602
Supplementary funds	1	39

Total	11	867

^{a/} For information source, see the 1992 revised post authorization table,
dated 23 July 1991.
